

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

05897

Reg. Dist. No. 64

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County CarolineCity or town Federalsburg - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Federalsburg - Reliance Road

How long in hospital or institution?

3. (a) FULL NAME

Kenneth S. Butler

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Single</u>
--------------------	-------------------------------	---

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) May 6, 1921

8. AGE: Years <u>24</u>	Months <u>1</u>	Days <u>3</u>	If less than one day hrs. min.
-------------------------	-----------------	---------------	--

9. Birthplace Choptank, Maryland
(Town, county and state)10. Usual occupation Seaman11. Industry or business U.S. Merchant Marine

12. Name <u>Bruce E. Butler</u>

13. Birthplace Caroline County, Maryland14. Maiden name Hattie E. Carroll15. Birthplace Dorchester County, Maryland16. Informant Mrs. Isabel FleetwoodAddress Seaford, Delaware17. Burial Burial (Burial, cremation, or removal. Which?) Date thereof June 13, 1945 (month) (day) (year)Cemetery or crematory Linchester CemeteryLocation Preston, Maryland18. Funeral director J. J. Frampton & SonAddress Federalsburg, Maryland19. Date June 13, 1945 (Date rec'd by registrar) J. J. Frampton

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarolineCity or town Federalsburg (If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2.(a) If veteran, name war Seaman - U.S. Merchant Marine

3. (b) Social Security Number

212-16-7115

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1945 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death _____ DURATION _____

Due to Shock - due to concurrent
Fracture of upper & lower jaws -
probably internal hemorrhage deadly

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

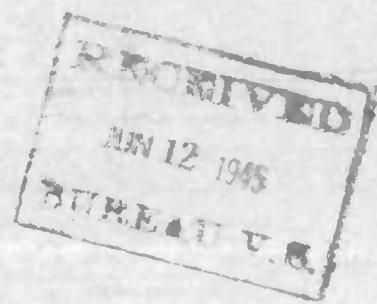
Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6/9/45Where did injury occur? No Federalsburg (City or town) Caroline (County) Md. (State)Injured at home, farm, industry, public place (where?) State HighwayMeans of injury Fell from Motorcycle Injured at work? No23. SIGNATURE George O. George M. D. or otherAddress Denton Date signed 6/10/45





MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

05899

CERTIFICATE OF DEATH

Reg. Dist. No. 64

1. PLACE OF DEATH:

County CarolineCity or town Federalburg - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

Near Chestnut Grove

How long in hospital or institution?

3. (a) FULL NAME

Florence E. Gross

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

Clarence Gross

7. Birth date of deceased (mo., day, yr.)

January 15 19066. (c) If alive, give age 38 years

8. AGE:

Years 39Months 4Days 28

If less than one day

hrs. min.

9. Birthplace

Caroline County, Maryland

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

Home12. Name William Setterfield

MOTHER FATHER

13. Birthplace Caroline County, Maryland

MOTHER

14. Maiden name Roxie Coursey

FATHER

15. Birthplace Sussex County, Delaware

16. Informant

Clarence Gross

Address

Federalburg, Maryland, R.F.D.

17. Burial

(Burial, cremation, or removal. Which?) Burial Date thereof June 16 1945

(month) (day) (year)

Cemetery or crematory

St Paul Cemetery

Location

Near Concord, Maryland

18. Funeral director

J. J. Frampston and Son

Address

Federalburg, Maryland

19. June 15 1945

(Date rec'd by registrar)

J. J. Frampston

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty CarolineCity or town Federalburg - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Near Chestnut Grove

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

220-03-8420

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 13

1945

at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 10

1945

to

June 13 1945and that I last saw him alive on June 10 1945

Immediate cause of death

Chronic Myo Carditis; ten months

DURATION

exacerbatedDue to Natural Causes

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

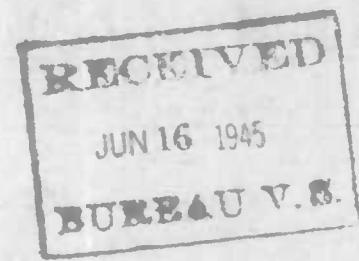
Injured at work?

23. SIGNATURE

R. D. Drayton

M. D. or other

Address Federalburg, Maryland Date signed 6-14-45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

CERTIFICATE OF DEATH

Reg. Dist. No. 62

05900

62

1. PLACE OF DEATH:

County

Cardfiss

City or town

Near Fredericks

Street address, hospital, or institution:

Stay in hospital or Inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 8 yrs

3. (a) FULL NAME

Mathilda L. Hawthorne

4. Sex

F

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Fred Hawthorne

7. Birth date of deceased (mo., day, yr.)

Sept. 17 1874

6. (c) If alive, give age 70 years

8. AGE:

Years
70Months
9Days
12If less than one day
hrs. min.

9. Birthplace

Sweden

(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

MOTHER FATHER

John Peterson

12. Name

Sweden

13. Birthplace

near Boston

14. Maiden name

Sweden

15. Birthplace

16. Informant

Fred Hawthorne

Address

R. D. Develine and

17. Buried

Date thereof 6-20-45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Lancaster Cemetery

Location

May Preston Rd

18. Funeral director

J. Siegel & Son

Address

Develine and

19. 6-18 1945

(Date rec'd by registrar)

Tom & George

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Caroline

City or town

Wester

Ward No.

1

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 17 1945, at 11:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 17 1945, to June 17 1945
and that I last saw him alive on June 17 1945

Immediate cause of death

DURATION

Cerebral Hemorrhage 18 hrs
Due to Chronic Myocarditis 4 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

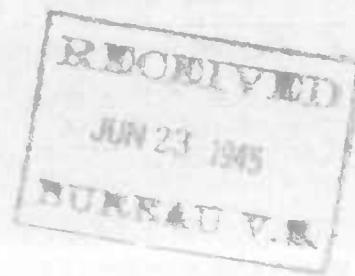
Aurora & George

M. D. or other

Address

Dentist

Date signed 6/18/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

05901

CERTIFICATE OF DEATH

Reg. Dist. No. 61

1. PLACE OF DEATH:

County

Caroline

City or town

Greensboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

4 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ella J. Hise

4. Sex

F

5. Color or race

W

6. (a) Siegle, married, widowed, or divorced

Married

B.(b) Name of husband or wife

John H. Hise

B.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.)

April 12, 1869

8. AGE:

Years
76Months
2Days
16

If less than one day

hrs.

min.

9. Birthplace

Rome Pa.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Martin B. Moore

FATHER

12. Name

Martin B. Moore

13. Birthplace

Pa

MOTHER

14. Maiden name

Jane Lent

15. Birthplace

Pa

16. Informant

Mrs. Celeste Rouse

Address

Greensboro Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof July 7, 1945
(month) (day) (year)

Cemetery or crematory

Greensboro

Location

Greensboro Md.

18. Funeral director

Raymond B. Pawlucy

Address

Greensboro Md.

19. Date rec'd by registrar

Dec 29, 1945 L. Melega

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Caroline

City or town

Greensboro

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 28 1945 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 20 1945 to June 28 1945

and that I last saw her alive on June 27 1945

Immediate cause of death

Amenia

Due to

Acute Suffocation

Due to

Cerebral Hemorrhage

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, Industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

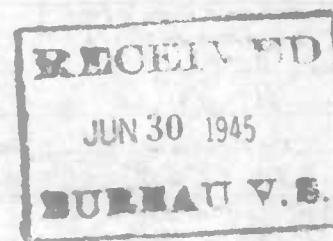
Date signed

M.D. or other

Address

Date signed

1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Q.P.*

05902

CERTIFICATE OF DEATH

Reg. Dist. No. 66

1. PLACE OF DEATH:

County.....

City or town.....

*Caroline**Ridgely*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

40 yrs

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Herbert Simpson

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Caroline

City or town.....

Ridgely

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

*None**Jones*

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 12

19 45 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 27 1945 to *June 12* 1945and that I last saw him alive on *June 12* 1945

Immediate cause of death

*Mitral stenosis**and regurgitation**Doctor 2 Hypertrophy and loss 4 yrs**Due to Acute rheumatic fever - year up**Other conditions Hemorrhage at**Prosthetic hyper trophy 1939*

10-2-42

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results

no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address.....

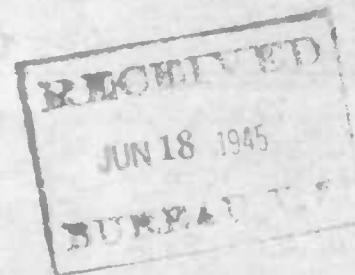
J. D. Davis Date signed *6-14-40*

19. Date rec'd by registrar

(Date rec'd by registrar)

19. Date rec'd by registrar

(Date rec'd by registrar)



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

05903

CERTIFICATE OF DEATH

Reg. Dist. No. 64

1. PLACE OF DEATH:

County CarolineCity or town Federalburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1/2 hrHospital, Institution, or street address where death occurred: Benton RoadHow long in hospital or institution? -

3. (a) FULL NAME

Mary Viola Magee4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single6. (b) Name of husband or wife -7. Birth date of deceased (mo., day, yr.) May 23, 1945 6. (c) If alive, give age - years8. AGE: Years - Months - Days 21 If less than one day hrs. - min.9. Birthplace Federalburg, Maryland
(Town, county, and state)10. Usual occupation Infant11. Industry or business -FATHER 12. Name Wilmer Magee13. Birthplace Federalburg, MarylandMOTHER 14. Maiden name Mary Agnes DeSilets15. Birthplace Dorchester County, Maryland16. Informant Wilmer MageeAddress Federalburg, Maryland17. Burial Date thereof June 16, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Federal Hill CemeteryLocation Federalburg, Maryland18. Funeral director J. J. Frampton and SonAddress Federalburg, Maryland19. Date June 15 1945 J. J. Frampton
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarolineCity or town Federalburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. Benton Road

(If rural, give LOCATION)

2.(a) If veteran, name war -

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1945 at 6:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 - 1945 to June 14 - 1945 and that I last saw her - alive on July 14 - 1945.Immediate cause of death Bronchopneumonia 3 days

DURATION

Due to -Due to -Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations - Date of op. -Autopsy results - PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury - Injured at work? -23. SIGNATURE Franklin Anderson M.D. M. D. or other -Address Federalburg, Maryland Date signed 6/15/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

15904

CERTIFICATE OF DEATH

Reg. Dlat. No. 62

1. PLACE OF DEATH:

County.....

City or town..... Denton Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Kate Reed

4. Sex

70.

5. Color or race

80

6.(a) Single, married, widowed, or divorced

widow

6.(b) Name of husband or wife

Leemuel Reed Dees

7. Birth date of

deceased (mo., day, yr.)

Mar. 25th 1861

6.(c) If alive, give age..... years

8. AGE:

84

Years

3

Months

18

Days

If less than one day
hrs. min.

9. Birthplace.....

Maryland

(Town, county and state)

10. Usual occupation.....

at home

11. Industry or business

FATHER

12. Name.....

John Buckmaster

13. Birthplace

Maryland

14. Maiden name.....

Kate

15. Birthplace

Maryland

16. Informant.....

Mrs. George Reed

Address

Denton Md.

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

6/13

1945

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Caroline

City or town.....

West Denton

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 11th 1945 at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 29, 1945 to June 11, 1945
and that I last saw her alive on June 7th 1945

Immediate cause of death

Arthur A. Dennis

DURATION

10 years

Due to.....

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE

D. Paul Knotts M.D.

M. D. or other

Address.....

Denton Md.

Date signed 6/13/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

05905

CERTIFICATE OF DEATH

Reg. Dist. No. 60

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m. 20. married

6. (b) Name of husband or wife.....

Anna Rudder

7. Birth date of

deceased (mo., day, yr.)

Sept. 30 1869

8. (c) If alive, give age 73 years

8. AGE: Years 75 Months 8 Days 23 If less than one day

9. Birthplace.....

Green Acre - Md.

(Town, county, and state)

10. Usual occupation.....

Office work

11. Industry or business

MOTHER FATHER

12. Name.....

John G. Rudder

13. Birthplace.....

Md.

14. Maiden name.....

Ann Lucas

15. Birthplace.....

Md.

16. Informant.....

John G. Rudder

Address.....

Deutsche Kref

17. Buried.....

(Burial, cremation, or removal. Which?)

Deutsche Kref

Date thereof 6-26-45

(month) (day) (year)

Cemetery or crematory.....

Deutsche Kref

Location.....

Deutsche Kref

18. Funeral director.....

J. D. G. Rudder

Address.....

Deutsche Kref

19. 6/25 1945

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Caroline

City or town.....

Deutsche Kref

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

June 23 1945 et. 10A M

June 23 1945 to June 23 1945

and that I last saw him alive on June 23 1945

Immediate cause of death.....

Cardiac Embolus

Due to.....

3 hr.

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

21. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

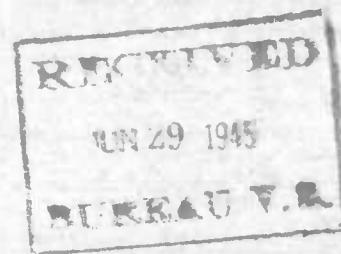
M. D. or other

Address.....

Deutsche Kref

Date signed.....

6/26/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2411 N. Charles St., Baltimore 1911

CERTIFICATE OF DEATH

05906

Reg. Dist. No. 62

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

John Green Sexton

4. Sex

m

5. Color or race

br.

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife:.....

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age..... years

July 29th 1865

8. AGE:

Years
80Months
—Days
19

If less than one day

hrs. min.

9. Birthplace.....

New York City

(Town, County, and state)

10. Usual occupation.....

11. Industry or business

FATHER

12. Name.....

Michael Sexton

13. Birthplace

England

MOTHER

14. Maiden name.....

Adeline Grier

15. Birthplace

Penn.

16. Informant.....

Mary D. Sexton

Address

Buried at Deuel - Eng.

17. (Burial, cremation, or removal. Which?)

Date thereof.....
(month) (day) (year)
6-19-45

Cemetery or crematory

Tully Cross Cemetery

Location

West of Deuel

18. Funeral director

J. Vigil Leonard & Son

Address

Deuel - Eng.

19. (Date rec'd by registrar)

1945

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Frederick

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

June 17

1945 at 5:30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 17 1945 to June 17 1945

and that I last saw him alive on

19

Immediate cause of death.....

died in my

DURATION

Due to.....

Arteriosclerosis

-1

Due to.....

Heat stroke

3 days

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

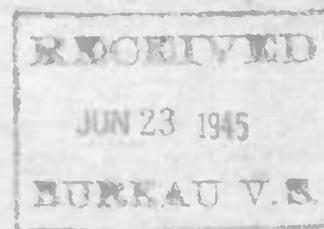
Thomas & George Co.

M. D. or other

Address.....

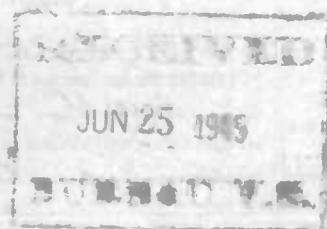
Denton

Date signed 6/18/45



RECEIVED BY TELETYPE STATE GOVERNOR

RECEIVED 200307070000





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

05908

CERTIFICATE OF DEATH

Reg. Dist. No. 64

1. PLACE OF DEATH:

County CarolineCity or town Federalburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? _____

3. (a) FULL NAME

W. Lee Wheatley4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Roberta B. Wheatley7. Birth date of deceased (mo., day, yr.) September 23, 1875 8.(c) If alive, give age 67 years8. AGE: Years 69 Months 8 Days 27 If less than one day _____ hrs. _____ min.9. Birthplace Dorchester County, Maryland (Town, county, and state)10. Usual occupation Canner11. Industry or business Tomato Packing12. Name Social J. Wheatley13. Birthplace Dorchester County, Maryland14. Maiden name Ella Brinsfield15. Birthplace Dorchester County, Maryland16. Informant Mrs. Roberta B. WheatleyAddress Federalburg, Maryland17. Burial Burial Date thereof June 22, 1945 (Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Hick Crest CemeteryLocation Federalburg, Maryland18. Funeral director J. J. Frampton & SonAddress Federalburg, Maryland19. Date rec'd by registrar June 21st 1945 J. J. Frampton
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarolineCity or town Federalburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20, 1945 at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 20, 1945 to June 20, 1945and that I last saw her alive on June 20, 1945

Immediate cause of death

Coronary Thromboses

DURATION

1 hr.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

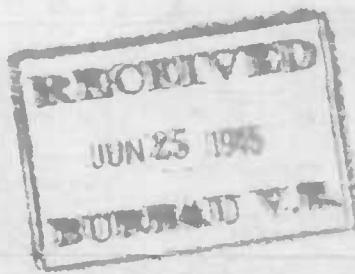
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury _____ Injured at work? _____

23. SIGNATURE Frank M. Anderson, M.D. M. D. or otherAddress Federalburg, Maryland Date signed 6/21/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

15909

CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Lucy Ann McRile

4. Sex

F

5. Color or race

6. (a) Single, married, widowed, or divorced

Dr. Sheldon

6. (b) Name of husband or wife.....

Lucy Ann McRile - Dec 1945

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

Jan. 27th 1876

8. AGE:

Years
69Months
4Days
4If less than one day
hrs. min.

9. Birthplace.....

(Town, county, and state)

Ireland

10. Usual occupation.....

House work

11. Industry or business

FATHER

12. Name..... Joseph Burk

13. Birthplace..... Ireland

MOTHER

14. Maiden name..... Lucy Mc Daugh

15. Birthplace..... Ireland

16. Informant..... Mrs. Ward

Address..... Dublin

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof..... 6-9-45
(month) (day) (year)

Cemetery or crematory..... Dublin Cemetery

Location..... John Deuelant

18. Funeral director..... Siegel Mason & Son

Address..... Dublin Ind.

19. (Date rec'd by registrar)

1945

M. D. or other

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Ind. Dublin

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

June 7th 1945 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 10 1945 to June 6 1945

and that I last saw her alive on June 6 1945

Immediate cause of death.....

Sept. 1945

DURATION

Due to.....

Cited Mental Disease

(7)

Due to.....

Cited Mental Disease

(7)

Due to.....

Other conditions..... June 6 1945

(7)

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

Black & Deuelant M. D. or other
Glenelton Ave Date signed 1945

